STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395331	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Laurel Healthcare and Rehabilitation Ctr	700 Leonard Street Clearfield, PA 16830

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of policies and clinical record reviews, as well as staff interviews, it was determined that the facility failed to readmit a resident following a hospitalization for one of eight residents reviewed (Resident 1). Findings include:The facility's policy regarding transfers and discharges, dated April 10, 2026, revealed that for circumstances where the discharge is necessary for the resident's welfare and the facility cannot meet the resident's needs, the resident's physician would document information about the basis for the discharge. If the facility determined that it could not meet the resident's needs , the resident's physician would document the specific resident needs that could not be met, the facility's attempts to meet the resident's needs, and the specific service available at the receiving facility to meet the needs of the resident which could not be met at the current facility. In situations where the facility had decided to discharge the resident while the resident was still hospitalized , the facility would send a notice of discharge to the resident and resident representative before the discharge and must also send a copy of the discharge notice to a representative of the Office of the State Long Term Care Ombudsman. If the resident chooses to appeal the discharge, the facility would allow the resident to return to his or her room or an available bed in the nursing home during the appeal process, unless there was documented evidence that the resident's return would endanger the health or safety of the resident or other individuals in the facility. A nursing note, date April 3, 2026, at 12:34 a.m. revealed the resident was admitted to the facility on [DATE]. Nursing notes for Resident 1, dated April 3, 2026, at 5:27 p.m. revealed that Resident 1 tied a sheet around his neck and stated, I don't want to live like this anymore. The police and Emergency Medical Personnel (EMS) were present, and the resident was transferred to the hospital for treatment. A nursing note, dated April 3, 2026, at 8:24 p.m., revealed that the hospital was told that the facility would be unable to accept Resident 1 back due to not being able to meet the resident's needs. Interview with the Nursing Home Administrator on June 3, 2026, at 11:27 a.m. confirmed that Resident 1 was not returning to the facility and the facility was unable to meet Resident 1's needs due to him attempting suicide and being a big risk factor. She confirmed that there was no written reason from the physician why the resident's needs could not be met, the facility's attempts to meet the resident's needs, and the specific services available at the receiving facility to meet the needs of the resident that could not be met at the current facility. Interview with the Director of Nursing on June 3, 2026, at 12:23 p.m. confirmed that there was no documented evidence that a written notice regarding Resident 1's discharge from the facility was provided to the resident, resident representative and State Ombudsman. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18 (b)(2) Management. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.12 (d)(3) Nursing services.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395331	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Laurel Healthcare and Rehabilitation Ctr	700 Leonard Street Clearfield, PA 16830

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to notify the resident and/or the resident's representative, in writing regarding the reason for transfer to the hospital and failed to notify the ombudsman of the transfer to the hospital, for two of eight residents reviewed (Residents 1, 6). Findings include:The facility's policy regarding transfers and discharges, April 10, 2026, revealed that the facility's transfer notice and bed hold policy would be provided to the residents and representatives when indicated. A nursing note dated April 3, 2026, at 12:34 a.m. revealed the resident was admitted to the facility on [DATE]. Nursing notes for Resident 1, dated April3, 2026, at 5:27 p.m. revealed that Resident 1 tied a sheet around his neck and stated, I don't want to live like this anymore. The police and Emergency Medical Personnel (EMS) were present, and the resident was transferred to the hospital for treatment. Review of Resident 1's clinical record revealed that there was no documented evidence that the resident and legal guardian were notified in writing of the purpose for the resident's hospitalization of April 3, 2026. An admission Minimum Data Set (MDS) assessment (a mandatory assessment of a resident's abilities and care needs) for Resident 6, dated April 22, 2026, revealed that the resident is cognitively intact, required assistance with daily care needs and had medical diagnoses that included cellulitis of right lower limb and acquired absence of right toes. A nursing note for Resident 6, dated April 23, 2026, at 13:10 p.m. revealed that the resident was transferred to the hospital with a worsening foot wound. Review of Resident 6's clinical record revealed that there was no documented evidence that the resident and legal guardian were notified in writing of the purpose for the resident's hospitalization of April 23, 2026. Interview with the Nursing Home Administrator on June 3, 2026, at 1:19 p.m. confirmed that there was no documented evidence that Resident 1 and Resident 6 or their representative were notified in writing of their transfer to the hospital. 28 Pa. Code 201.29(j) Resident Rights.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395331	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Laurel Healthcare and Rehabilitation Ctr	700 Leonard Street Clearfield, PA 16830

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure the accountability of controlled medications (drugs with the potential to be abused) for three of eight residents reviewed (Residents 5, 7, 8). Findings include: The facility's policy regarding controlled substance administration and accountability, April 10, 2026, indicated that the Controlled Drug Record was a permanent medical record document and in conjunction with the Medication Administration Record (MAR) was the source for documenting any patient-specific narcotic dispensed from the pharmacy. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 5 dated April 9, 2026, indicated that the resident was cognitively intact, required assistance with daily care needs, received an opioid medication (a controlled medications used to treat pain), and was receiving hospice services. Physician's orders for Resident 5, dated March 30, 2026, included an order for the resident to receive 0 .25 milliliters (ml) of Morphine (a controlled narcotic pain medication) orally every 2 hours as needed for moderate pain/anxiety. A review of Resident 5's controlled drug record (used to keep count of narcotic medication) for May 2026 revealed that staff signed out 0.25 ml Morphine on May 18, 2026, at 11:00 p.m. and 2:00 a.m., however, review of the resident's MAR, dated May 2026, revealed no documented evidence that the 0.25 ml of Morphine was administered to the resident on those dates. The controlled drug record for Resident 5 for May 2026 also revealed that the amount of Morphine available on May 29, 2026, at 12:09 p.m. was 12.75 ml. The amount of Morphine available on May 29, 2026, at the time the first shift nurse and second shift nurse counted narcotics, was 6.0 ml. There was no documented evidence that an investigation was initiated to determine the possible cause of the missing amount of Morphine. A significant change MDS assessment for Resident 7 dated, April 7, 2026, indicated that the resident was cognitively impaired, required assistance with daily care needs, and had diagnoses that included heart failure and dementia. Physician's orders for Resident 7 dated May 18, 2026, included an order for the resident to receive 0.5 mg (milligrams) of Lorazepam (a controlled medication for anxiety) orally every 4 hours as needed for anxiety. The controlled drug record for Resident 7 for May 2026 revealed that staff signed out 0.5 milligrams of Lorazepam on May 17, 2026, at 2:00 a.m.; 28, 2026 at 8:00 p.m.; May 29, 2026, at 8:00 p.m.; May 30, 2026, at 8:00 p.m.; May 31, 2026, at 8:00 p.m. However, review of the resident's MAR, dated May 2026, revealed no documented evidence that 0.5 mg of Lorazepam was administered to the resident on those dates. An annual MDS assessment for Resident 8 dated April 9, 2026, indicated that the resident was moderately cognitively impaired, required assistance with daily care needs, had pain occasionally, received pain medications as needed, received an opioid medication (a controlled medication used to treat pain), and had diagnoses that included pancreatic disease. Physician's orders for Resident 8, dated April 15, 2026, included an order for the resident to receive 0.5 ml of Morphine orally every 1 hour as needed for severe pain or respiratory distress. A review of Resident 8's-controlled drug record for May 2026 revealed that staff signed out 0.5 ml of Morphine on May 2 at 4:40 p.m. and 7:40 p.m., and on May 26, 2026, at 4:11 p.m. However, review of the resident's MAR, dated May 2026, revealed no documented evidence that the 0.5 ml of Morphine was administered to the resident on those dates. Interview with the Director of Nursing on June 3, 2026, at 1:47 p.m. and 4:14 p.m. confirmed that there was no documented evidence that the doses of Resident 5 and 8's Morphine signed out by the nurse was actually administered on the above dates and that Resident 5's Morphine was unaccounted for and there was no investigation initiated regarding the missing Morphine. She confirmed that there was no documented evidence that the dose of Resident 7's Lorazepam signed out by the nurse was actually administered on the above dates. 28 Pa. Code 211.9(h) Pharmacy Services.28 Pa. Code 211.12(d)(1) Nursing Services.